Personal Care Services (age 21 and over)

(Refer to the Miscellaneous chapter of this manual for those under age 21)

Definition: Active, hands-on assistance in the performance of Activities of Daily Living (ADL's) or Instrumental Activities of Daily Living (IADL's) provided to the waiver participant in his/her home. This service may only be provided in other locations when defined in the Support Plan. ADL's include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and assistance with ambulation. If it is determined that a participant requires more than one personal care aide, this must be prior-approved by DDSN and documented on the Support Plan. IADL's include light housework, laundry, meal preparation and shopping. These IADL activities are for the specific needs of the participant, not the general needs of the household. IADL's may also include home safety, assistance with communication, medication monitoring – to include informing the participant that it is time to take medication prescribed by his/her physician or handing the participant a medication container – and limited assistance with financial matters, such as delivery of payments as directed by the participant on his/her behalf.

Authorizations to providers will be made at two different payment levels. Based on DDSN assessed need, the higher level service, Personal Care 2, may be considered appropriate when the care needed for assistance with ADL's alone or in conjunction with assistance with IADL's/home support. Based on DDSN assessed need, the lower level service, Personal Care 1, may be considered appropriate if the only needed care is for IADL's/home support activities. PC 1 does not include hands-on care.

Personal Care 2 services may include escort and transportation when necessary. This must be specifically documented on the Support Plan; there must be no other resources available; and, the provision of transportation will depend upon the personal care provider's policy in this regard.

Personal Care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior-approved by a licensed physician. The Nurse Practice Act is available on the following web page: http://www.scstatehouse.gov/code/t40c033.htm

Both services allow the provider to accompany the participant on visits in the community when the visits are related to the needs of the participant, specified in the Support Plan, and related to needs for food, personal hygiene, household supplies, pharmacy or durable medical equipment. The Service Coordinator has the responsibility to identify the necessity of the trip, document the need in the Support Plan, authorize this component of the service, and monitor the provision of the services.

The unit of service is 15 minutes, provided by one Personal Care Aide (PCA).

Please see: Scope of Services for Personal Care 1 (PC 1) Services
Scope of Services for Personal Care 2 (PC 2) Services

Service Limits: Personal Care 2 Services are limited to a maximum of 28 hours (112 units) per week, as determined by SCDDSN assessment. A week is defined as Sunday through Saturday. When Personal Care 2 is authorized in conjunction with Adult Attendant Care and/or Adult Companion Services, the combined total hours per week of services may not exceed 28. Unused units from one week cannot be banked (i.e. held in reserve) for use during a later week.

Personal Care 1 Services are limited to a maximum of 6 hours (24 units) per week, as determined by SCDDSN assessment.

Participants receiving Residential Habilitation may not receive Personal Care (1 or 2) Services through the MR/RD Waiver.

Providers: Personal Care Services must be provided to participants by an agency contracted with the Department of Health and Human Services. The recipient/family should be given a listing of available providers from which to choose. **The offering of this provider choice must be documented**

Agencies contracted with the Department of Health and Human Services must adhere to the requirements noted in the Scope of Services for Personal Care Services (1 and 2) for the MR/RD Waiver, which specifies the minimum qualifications for a PCA 1 and for a PCA 2.

Arranging for and Authorizing Services: The need for the service must be documented in the participant's Support Plan. To assess the need for Personal Care Services, the Service Coordinator must complete the Personal Care/Attendant Care Assessment for Adults (MR/RD Form 34). The Support Plan must also include documentation of the amount, frequency, duration and provider type of the service. Personal Care Services (1 or 2) are approved at the local level.

The participant/family should be given a listing of available providers from which to choose. This offering of provider choice must be documented. Once the service is approved and an agency is selected, the Service Coordinator should complete the Authorization for Personal Care Services (MR/RD Form A-3) and send a copy to the chosen agency. This authorization remains in effect until a new/revised Authorization for Personal Care Services (MR/RD Form A-3) is sent or until services are terminated (see Chapter 8).

Monitoring Services: The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Personal Care Services (1 and 2):

- During the first month of service, monitoring should be conducted while the service is being provided, unless the Service Coordination Supervisor documents an exception. An exception can only be made when the service is provided in the late evening or early morning hours (between 9:00 pm and 7:00 am).
- Services should be monitored at least once during the second month of service.
- Services should be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.
- The monitoring schedule must start over any time there is a change of personal care provider.
- Monitoring should be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Monitoring must be conducted by contact with the participant/family. It can be supplemented with contact with the service provider.
- Review the daily logs completed by the aides (Note: Daily logs can be requested from personal care providers as often as needed for monitoring purposes and must be requested for all on-site visits). .
- Monitoring of the participant's health status should always be completed as a component of Personal Care monitoring.

Some questions to consider during monitoring include:

- Is the participant receiving Personal Care services as authorized?
- Does the PCA show up on time and stay the scheduled length of time?
- Does the provider show the participant courtesy and respect?

- ❖ Has the participant's health status changed since your last monitoring? If so, does the service need to continue at the level at which it has been authorized?
- ❖ Is the participant pleased with the service being provided, or is assistance needed in obtaining a new provider?
- ❖ What kinds of tasks is the PCA performing for the participant?
- ❖ If the PCA does not show up for a scheduled visit, who is providing back-up services?
- ❖ Who is providing supervision of the PCA? How often is on-site supervision taking place?

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
PERSONAL CARE/ATTENDANT CARE ASSESSMENT FOR ADULTS

WAIVER PARTICIPANT'S NAME: _____ DOB/AGE: _____/_____

Service(s) Requested ☐ PC 1 ☐ PC 2 ☐ Attendant Care

I. PLEASE LIST ALL MEDICAL CONDITIONS AND WHEN EACH CONDITION FIRST OCCURRED. USE AN EXTRA SHEET OF PAPER IF YOU NEED MORE SPACE.

	DIAGNOSIS/MEDICAL CONDITION	DATE FIRST OCCURRED
1.		
2.		
3.		
4.		

II. LIST ALL PERSONS INCLUDING PAID SERVICE PROVIDERS (E.G., NURSES, RESPITE CARE, ETC) WHO ARE NOW HELPING CARE FOR THE PARTICIPANT. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

PERSON/RELATIONSHIP	**TIMES** EACH DAY & **DAYS** EACH WEEK WHEN HELPING

III. PROVIDE A TWO WEEK SCHEDULE THAT SHOWS HOW/WHEN SERVICES/SUPPORTS (INCLUDING NATURAL SUPPORTS) ARE PROVIDED. INCLUDE THE ANTICIPATED SCHEDULE FOR PERSONAL CARE. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

ASSISTANCE NEEDED	ASSISTANCE REQUIRED	FREQUENCY, TIME REQUIRED, TIMES PER WEEK

A. PERSONAL CARE

BATH: BED ☐ SHOWER/TUB ☐	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
SHAVING:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 15 MIN ☐ OTHER ___, ___X WEEKLY
ORAL HYGIENE:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
SKIN CARE:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
DRESSING AND GROOMING:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 15 MIN ☐ OTHER ___, ___X WEEKLY
INCONTINENCE CARE:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
TOILETING:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 15 MIN ☐ OTHER ___, ___X WEEKLY
RE-POSITIONING/TURING IN BED:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
MONITORING MEDICATION:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY

(E.G., INFORMING THAT IT IS TIME TO TAKE MEDICATION AS PRESCRIBED OR AS INDICATED ON THE LABEL OR HANDING A MEDICATION CONTAINER – THE AIDE IS NOT RESPONSIBLE FOR GIVING MEDICATIONS).

MEDICAL MONITORING OF CONDITION - SPECIFY:

(E.G. MONITOR TEMPERATURE, CHECK PULSE RATE, OBSERVE RESPIRATORY RATE OR CHECK BLOOD PRESSURE)

_____	PARTIAL ☐ TOTAL ☐	FREQUENCY, TIME REQUIRED _____, ___X WEEKLY
_____	PARTIAL ☐ TOTAL ☐	FREQUENCY, TIME REQUIRED _____, ___X WEEKLY
EXERCISE:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER _____, ___X WEEKLY
TRANSFERS:		
MANUAL ☐	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
HOYER ☐	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
SLIDING BOARD ☐	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
LIFT SYSTEM ☐	PARTIAL ☐ TOTAL ☐	___ X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
OTHER: _____	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
OTHER PERSONAL CARE NEEDS:		
_____	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
_____	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY

ASSISTANCE/TIME NEEDED FOR PERSONAL CARE (TOTAL SECTION A): _____

B. MEAL AND DINING

PREPARATION AND SET-UP:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
DINING/FEEDING:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
CLEAN UP:	PARTIAL ☐ TOTAL ☐	___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY

ASSISTANCE/TIME NEEDED FOR MEALS/DINING (TOTAL SECTION B): _____

C. GENERAL/HOUSEHOLD

FLOOR CLEANING PARTICIPANT'S ROOM/AREA:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 15 MIN ☐ OTHER ___
DUSTING PARTICIPANT'S ROOM/AREA:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 15 MIN ☐ OTHER ___
STRAIGHTENING PARTICIPANT'S ROOM/AREA:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 30 MIN ☐ OTHER ___

CHANGING BED LINENS:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 15 MIN ☐ OTHER ___
PARTICIPANT'S LAUNDRY:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 90 MIN ☐ OTHER ___
SHOPPING:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 60 MIN ☐ OTHER ___
ESCORT:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 60 MIN ☐ OTHER ___
TRANSPORTATION:	PARTIAL ☐ TOTAL ☐	___ X WEEKLY, 60 MIN ☐ OTHER ___

ASSISTANCE/TIME NEEDED GENERAL/HOUSEHOLD (TOTAL SECTION C): _____

D. Other Needs

Shopping Assistance*:	Errands	__ x Weekly, 60 Min ☐ Other _____
	Escort	__ x Weekly, 60 Min ☐ Other _____
Assistance with Communication:		__ x Weekly, 60 Min ☐ Other _____

ASSISTANCE/TIME NEEDED FOR OTHER NEEDS (TOTAL SECTION D): _____

TOTAL ASSISTANCE/TIME NEEDED IN ALL AREAS: _____

NOTES:

_____ _____

SIGNATURE OF PERSON COMPLETING/TITLE **DATE**

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR PERSONAL CARE SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

You are hereby authorized to provide ☐ **Personal Care 1 (S5130)** ☐ **Personal Care 2 (T1019)** ***for:***

Participant's Name: _____ **Date of Birth:** _____

Address: _____
_____
_____

Phone Number: _____ **Medicaid #:** _____ **Social Security #:** _____

Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # _____

Start Date: _____

Authorized Total – PC 1 __ Units per week (no more than 24 for adults age 21 and over; 1 unit = 15 minutes)

Authorized Total – PC 2 ___ Units per week (no more than 112 for adults age 21 and over; 1 unit = 15 minutes)

Service Tasks Requested:

☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
☐ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
☐ Monitoring conditions medications, home safety, and/or communication.
☐ Assistance with exercise, ambulation, positioning, etc.
☐ Escort services, errands, transportation

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____
_____

Phone #: _____

_____ _____
Signature of Person Authorizing Services Date